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S 000	Initial Comments Complaint# 1612641/IL85523 Statement of licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure a resident was positioned properly to prevent pressure to his hand and hip, the facility failed to implement pressure relieving interventions to prevent a decline in a pressure ulcer, the facility failed to identify a stage II pressure ulcer, and the facility failed to ensure an open skin concern was reported to the nurse.

These failures resulted in R1 sustaining purple/blue discolored blisters to his right hand, a stage 3 pressure wound to the right hand, an unstageable deep tissue injury of the right hip, an unstageable pressure wound to the right sacrum, and an unstageable pressure wound to the right

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S9999	Continued From page 2 elbow. This applies to 3 of 11 residents (R1, R6, R16) reviewed for pressure ulcers in the sample 19. The findings include: 1. The Minimum Data Set (MDS) of April 11, 2016 shows R1 is totally dependent on staff for positioning, transfers, dressing, toileting, hygiene, and bathing. The MDS shows R1 is always incontinent of urine and stool, uses a gastric feeding tube for nutrition, and has a tracheostomy tube. The MDS shows R1 does not have any skin concerns, or pressure ulcers. R1's May, 2016 Physician Order Sheet (POS) shows R1 has diagnoses to include chronic respiratory failure, and tracheostomy. On May 18, 2016 at 10:30 AM, R1 was in bed, positioned on his left side, with his right hand elevated on a pillow. R1's right hand had a large fluid filled, purple/blue discolored blister to his first finger, and two irregular, circular discolored black/blue/purple areas on the palm and lateral side of his right hand. R1 had a yellow, fluid filled blister to the top, side of his right hand, and blisters to his pinky finger, and the hand was reddened, swollen, and had pitting edema present when the nurse pushed on it. R1 had a large purple discolored fluid filled blister to his right hip with reddened edges. At 11:00 AM, E4 RN (Registered Nurse) and E5 (Wound Care Nurse) repositioned R1 onto his side, and R1 had a circular open area to his right elbow that the surveyor pointed out to E5. E5 said she was not aware the wound was there and it must be "new". E5 said she thought it was an abrasion and said "I think it's shearing." E5 removed R1's	S9999		

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hydrocolloid dressing to the right side of his coccyx and R1 had an irregular shaped wound with slough (dead tissue) present, and an irregular depth throughout the wound bed. E5 said the wound was a skin tear or abrasion, and the wound looked different from Monday when she last assessed it, and the wound now had some slough in the wound bed.

On May 20, 2016 at 2:00 PM, E9 removed a saturated incontinence brief from R1. E9 rolled R1 on his side, and R1's hydrochloride to his coccyx was rolled up and coming off, exposing the wound to urine. R1 had an open area over his coccyx with slough present.

R1's May 16, 2016 Nurse Note shows "Called to room by CNA [certified nurse assistant] due to blistering of fingers on right hand...Observed reddish area to base of right index finger at distal joint. Area appears to be misshapen in appearance with some difficulty on range of motion..."

The May 16, 2016 incident report for R1 shows "observed skin to entire right palm and fingers both top and bottom surfaces to be macerated from pressure/moisture. Observed small linear black areas, almost with scab formation texture to inner surface of 1st and digit..."

R1's Skin/wound notes dated May 17, 2016 shows "patient assessed on May 16, 2016 with the following findings. Patient has numerous blisters to right hand and fingers. Pinky finger has blister measuring 2.5 cm x 1.2 cm on the medial side, blister measuring 4.0 cm x 1.2 cm on the lateral side, blister measuring 1.0 cm x 0.8 cm on the top, and blister measuring 4.5 cm x 2.0 cm on the underside. Patient has blister on the

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lateral side of the right hand measuring 2.4 cm x 1.5 cm. Patient has blister on index finger measuring 3.0 cm x 1.3 cm Treatment order in place and carried out will monitor and continue with treatment until resolved."

R1's May 16, 2016 wound documentation shows an "abrasion to Coccyx" measuring 2.5 cm x 2.3 cm x less than 0.1 cm depth, with 100% granulation, and "wound improving as evidenced by decreased size" (on May 18, 2016 there was slough present to the wound bed).

R1's May 18, 2016 wound documentation shows "Stage II" to right elbow, 1.5 cm x 1.0 cm x 0.1 cm with 10% slough, and "during wound dressing changes today, right elbow noted to have open area."

The wound care physician's assessment dated May 23, 2016 shows R1 has a stage III pressure wound to the right dorsal hand (top of hand) measuring 3 x 1.0 cm x 0.1 cm, and an unstageable deep tissue pressure injury of the right hip measuring 1.8 cm x 4.5 cm. The May 23, 2016 wound care physician assessment shows the skin tear wound to R1's sacrum declined to an unstageable (due to necrosis - dead tissue) of the right sacrum with 75% necrotic tissue present. The same assessment shows the stage II pressure ulcer to R1's right elbow declined to an unstageable pressure wound (due to necrosis) with 75% necrotic tissue.

R1's At "risk for impaired skin integrity" care plan initiated on June, 19, 2015 shows interventions to include: "assess the skin daily, paying attention to bony prominence's", and "Avoid undue exposure to moisture due to incontinence or perspiration."

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On May 18, 2016 at 10:40 AM, E8 (CNA) said there were 2 times this week, (Monday and Wednesday) morning that she found R1 "soaking wet" and "wet from head to toe" and she could tell he had no rounds done on the night shift. E8 said she found R1 on Monday morning with blisters to his elbow, right hip, and hand and she reported it to the nurse. E8 said R1 was laying in urine for hours, and the urine was strong, and was on his skin. E8 said R1 already had a spot on his bottom prior to the blisters forming, and is supposed to be turned and given incontinence care every 2 hours. On May 18, 2016 at On May 18, 2016 at 1:55 PM, E8 said when she went into R1's room on Monday morning, R1 was laying on his side facing the window, with his right hand tucked under his hip, and his weight on his right arm and hip. E8 said R1 was "really soaked" and his right hand was wrinkly from being wet under him. E8 said R1's hand looked like "when you go into the pool and your hand gets wrinkly, that's what it looked like", and it was white like it had no circulation. E8 said she was crying when she saw R1, that is was unacceptable how he looked, and it looked like he had not been changed or turned at all during the night.

On May 18, 2016 at 11:35 AM, E6 (RN) said the CNA (E8) told her at approximately 7:20 AM, she wanted her to look at [R1]. E6 said R1's hand "definitely" had blisters on his right hand. E6 said R1's knuckle on his index finger was discolored, and he had a blister on his pinky. E6 said R1's skin on his hand was "whitish and wrinkly" on the palm, fingers, and hand. E6 said the CNA reported to her that R1 was laying on his hand when the CNA found him. E6 said R1's hand was not swollen prior to this, and she felt the moisture led to the wrinkly skin, and pressure caused the

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S9999	Continued From page 6 blisters. On May 18, 2016 at 2:45 PM, E11 said he has worked night shift in which he is the only CNA for the 100 and 200 wing (approximately 55 residents- R1 resides on the 200 wing) and is the only CNA for the 100 wing on PM shift this evening. E11 said it is very difficult to complete rounds which included repositioning and toileting/incontinence care every two hours when there is only one aide. E11 said it often is more like 2.5 hours in between turning and repositioning. On May 19, 2016 at 5:55 AM, E11 said on night shift when he is the only one working he usually does 2.5 to 3 (instead of 4) really good rounds with incontinence care and repositioning but cannot round and reposition every 2 hours. On May 19, 2016 at 9:30 AM, Z3 (Nurse Practitioner) said she was informed of the injury to R1's hand on Monday, Z3 looked at the wound to R1's bottom and said she was told it started as a skin tear, and now there was slough present in the wound, which would be a decline in the wound. Z3 said the decline in R1's coccyx wound was from pressure over the pressure point of his coccyx, and the weight of his body. Z3 said the blisters to R1's right hand and right hip were caused from the pressure from the hand and hip touching. Z3 said R1 should be able to heal, has not had a lot of skin issues, has proper nutrition, has good capillary refill, and does not have any vascular issues that she is aware of. On May 19, 2016 at 10:20 AM, Z1 (Primary Care Physician) said the blisters to R1's hand and hip are avoidable, and caused from pressure from the way R1 was positioned. Z1 said R1 has had a decline in the wound to his coccyx with the	S9999		

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presence of slough, and the decline is due to pressure over the coccyx.

On May 19, 2016 at 11:40 AM, E5 (wound care nurse) said she has not had any formal training in wound care.

On May 19, 2016 at 1:10 PM, E9 (CNA) said she worked Sunday night (May 15, 2016) to Monday morning. E9 said she was the only CNA for the 200 hall, and she left early, around 3:00 AM, because she worked the PM that evening, too. E9 said she was not positive when R1 was last changed/repositioned, but she did her last set of rounds around 2:00 AM, and she did not know of any skin concerns on R1 at that time. E9 said it is not realistic to toilet and provide incontinence care and reposition the residents every 2 hours on the evening shift when she is the only CNA on the hall, and she is scheduled as the only CNA on the 200 hall at least 3 times per week.

On May 23, 2016 at 2:00 PM, E5 said R1 should be repositioned, and checked for incontinence at least every 2 hours. E5 said a resident's skin should be monitored, cleaned, and barrier cream applied with every incontinent episode, especially if they are high risk for breakdown.

2. R6's MDS of March 30, 2016 shows R6 is totally dependent on staff for repositioning, and transfers, and requires extensive assistance with dressing, eating, hygiene, and bathing. The MDS shows R6 is always incontinent of bowel and bladder.

R6's wound assessment dated April 12, 2016 shows a full thickness wound to the coccyx as Moisture Associated Skin Damage, 1.9 cm x 0.5

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cm x 0.2 cm, small slit like wound to gluteal fold at coccyx level...

On May 19, 2016 at 5:25 AM, R6 was in bed on her back with her heels resting on the mattress. E11 (CNA) rolled R6 to her side, and her incontinence pad was saturated with urine. R6 had a hydrocolloid dressing on her coccyx, and had long thin open area to her right gluteal fold. E11 said the open area was new and "I have to report it". After removing the soiled linen, and without providing incontinence care, or applying barrier cream, E11 placed R6 onto her left side, with her heels resting on the bed.

On May 19, 2016 at 2:30 PM, R6 was in bed, and had a small open area, with depth to her upper coccyx. E4 and E5 said the area started as a crack but is now a pressure sore (has more depth). E4 said it started because when the CNAs clean her, they hold her over and her skin cracks from pulling on the skin. At 3:00 PM, this surveyor pointed out the open area to R6's right gluteal fold. E4 said the area was approximately 1.5 inches in length, and the CNA should have reported the open area to the nurse, and the nurse would report it to the wound care nurse. E5 said she did not know about R6's wound, and nothing was reported to her that day. E4 said the wound is from R6 being wet, and staff pushing R6 over to her side with moist skin, causing the fragile tissue to split.

At 3:10 PM, E12 (LPN) said she was R6's nurse for the day shift, and no new wounds were reported for R6. E12 said the CNA should report any new open area to the nursing staff.

R6's "At risk for impaired skin integrity" care plan initiated March, 26, 2014 shows Assess the skin

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daily, paying attention to bony prominences, avoid undue exposure to moisture due to incontinence or perspiration...Barrier cream to skin after each incontinence episode...Cleanse skin with a mild cleansing agent after soiling...Reposition frequently to prevent skin breakdown."

3. The MDS of May 10, 2016 shows R16 is cognitively intact, and requires extensive assistance from 2 staff with bed mobility, transfers, and is totally dependent on staff with toileting.

On May 19, 2016 at 2:30 PM, R16 was in bed, on his back. R16 said he was admitted to the facility because he needed treatment for his pressure ulcers. R16 said he put his call light on at 1:30 AM this morning to be repositioned, and the nurse did not come into the room until 5:00 AM. R16 said the last time he had been repositioned was 9:30 PM the night before so he was in the same position from 9:30 PM to 5:00 AM, and he has a pressure ulcer to his left foot and right buttock. R16 said the nurse told him she was working all alone and it was hard for her to see everyone. R16 said the staff members are not good about turning and repositioning him, he only gets turned if he calls them and asks them to. R16 said he is a quadriplegic, and is in a lot of pain when he is waiting to be turned, and the bed gets all wet from sweat. On May 20, 2016 at 12:23 PM, R16 had a wedge at the foot of his bed, and said he is too tall for the bed, they ordered a longer bed for him over a month ago but he is still waiting for it to be delivered, and he has the wedge in place to prevent his feet from resting on the footboard. R16 said he has been in a lot of places with staff issues in which he has to wait for help, but never as bad as this facility.

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R16's wound assessment shows on April 18, 2016, R16 had an unstageable area to his coccyx with 10% epithelial tissue and 90% granulation. The May 16, 2016 assessment shows a decline in the wound with a "full thickness wound to his coccyx" with 70% granulation, and 20% slough.. R16's April 18, 2016 wound assessment shows a partial thickness wound to R16's right thigh with 20% epithelialization, and 80% granulation. The May 16, 2016 assessment shows a decline in the partial thickness wound with 60% granulation and 20% slough.

R16's high risk for contractures care plan initiated March 14, 2016 shows "provide turning and repositioning per schedule."
R16's Impaired skin/tissue integrity care plan initiated March 18, 2016 shows "avoid undue exposure to moisture due to incontinence or perspiration...reposition at least every 2 hours...use lifting device or bed linens to move resident...

On May 24, 2016 at 10:05 AM, E5 said R3 is alert and oriented, and is compliant with repositioning. E5 said R3 can use his call light, to let staff know when he wants to be turned. E5 said R3 should be repositioned at a "bare minimum" of every 2 hours, and it would be nice if he was repositioned more often. E5 said she is not sure why R3's wounds are declining, and the coccyx wound is at a "stand still", and is not betting better.

The undated "Facility Policy: Management of Wounds" shows:
A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s)...
It is the policy of this facility to manage tissue load and improve tissue tolerance to pressure,

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S9999	Continued From page 11 friction,and shearing forces. this will be accomplished through the use of appropriate positioning practices, positioning devices, and support surfaces. The facility October, 2003 Incontinence Care policy states: "Incontinence care is provided to keep residents as dry, comfortable, and odor free as possible. It also helps in preventing skin breakdown. "Incontinent residents are changed every two hours and more frequently if needed...apply barrier cream if appropriate...notify nurse of areas of red skin or breakdown so that the physician or nurse practitioner may be notified for further orders." (B)	S9999		